RFI Draft Comments to HHS

A. State Exchange Planning and Establishment Grants

Section 1311(a) directs the Secretary to make planning and establishment grant awards to States for activities related to establishing an Exchange. For each fiscal year, the Secretary must determine the total amount that will be made available to each State. Grants awarded under this Section may be renewed if a State is making sufficient progress toward establishing an Exchange, implementing other insurance market reforms, and meeting other benchmarks. The Secretary must make the initial grant awards under this Section no later than one year after enactment, and no grants shall be awarded after January 1, 2015.

1. What factors are States likely to consider in determining whether they will elect to offer an Exchange by January 1, 2014? To what extent are States currently planning to develop their own Exchanges by 2014 (e.g., become electing States) versus choosing to opt-in to an Exchange operated by the Federal government for their State? When will this decision be made? Can planning grants assist in identifying and assessing relevant factors and making this decision?

Kentucky has concerns regarding federal regulation of the insurance market inside the exchange and its impact on state regulation outside the exchange. Dual-regulation could lead to instability in the Kentucky insurance market and other unintended negative consequences.

Given the current budget situation in Kentucky, sustainability of the exchange is an important factor that Kentucky is considering with regard to state operation of an exchange.

At this time, Kentucky is taking necessary steps to evaluate the impact of a state-operated exchange. The planning grants will be crucial to determining the feasibility of state election to operate an exchange. The final determination will be made in the Spring of 2011 after background research, IT assessments and evaluation of insurance market conditions have been performed.

2. To what extent have States already begun to plan for establishment of Exchanges? What kinds of activities are currently underway (e.g., legislative, regulatory, etc.)? What internal and/or external entities are involved, or will likely be involved in this planning process?

Planning for an exchange in Kentucky has begun. The Commonwealth of Kentucky, under the leadership of the Cabinet for Health and Family Services (the umbrella health and human services agency) and the Department of Insurance (insurance regulator) has recently held several stakeholder meetings with Providers, Consumer groups, Insurers, and Agents regarding development and implementation of a state exchange. Representatives from Kentucky have attended various conferences and seminars to seek guidance and direction for establishment of an Exchange. In the planning for operation of an exchange, the Commonwealth will most likely consult with public Universities and the Area Development Districts (ADD) to provide some research and analysis of the insurance market in Kentucky, including the uninsured population. Additionally, the Kentucky Commissioner of Insurance is a member of the Exchange subgroup of the National Association of Insurance Commissioners.

a. What kinds of governance structures, rules or processes have States established or are they likely to establish related to operating Exchanges (e.g., legal structure (such as placement in State agency or nonprofit organization), governance structure, requirements relating to governing board composition, etc.)?

The Commonwealth is still considering all options regarding governance.

b. To what extent have States begun developing business plans or budgets relating to Exchange implementation?

The Commonwealth will begin to develop business plans and proforma budgets as part of the planning grant process.

3. What are some of the major factors that States are likely to consider in determining how to structure their Exchanges (e.g., separate or combined individual Exchanges and SHOP Exchanges; regional or interstate Exchanges; subsidiary Exchanges, State agency versus nonprofit entity)? What are the pros and cons of these various options?

The following major factors will be considered in determining the structure of Kentucky's exchange: Adverse selection; Cost of operating multiple exchanges; sustainable business model; participation by insurers, employers, and individuals; Commonalities between laws, products, and markets; Preservation of the Association and "Employer-Organized Association" Markets (This entity is a specifically defined term and entity is specific to the Commonwealth).

4. What kinds of factors are likely to affect States' resource needs related to establishing Exchanges?

Budget shortfalls will continue to limit the state's ability to plan for, finance and operate a state-run exchange. The development and maintenance of a new complex IT system and its ability to interface with the Exchange and the current Medicaid system will be extremely expensive regardless of whether or not the state or federal government operates the exchange.

a. What is the estimated range of costs that States are likely to incur during the upcoming year (e.g., calendar 2010 through calendar 2011) for each of the major categories of Exchange activities? Which of these expenses are fixed costs, and which costs are variable?

One million dollars (specific estimates are in the planning grant application). Kentucky plans on applying for any additional applicable grant funds when these grants opportunities become available. Given the current budget situation in Kentucky, no state funds are available for planning or implementing an exchange. In addition to the exchange planning grant, Kentucky anticipates extensive use of current staff in a variety of planning, analysis, and public education activity.

b. To what extent do States have existing resources that could be leveraged as a starting point for Exchange operations (e.g., existing information technology (IT) systems, toll-free hotlines, Web sites, business processes, etc.)?

Kentucky has very limited resources. Currently, Kentucky is developing a website for health care reform implementation. At this time the Department of Insurance and Department for Medicaid Services maintain a toll-free hotline and help e-mail mailboxes for interested parties to submit questions or concerns.

The current Medicaid eligibility IT system is a mainframe system integrated with SNAP, TANF, and state supplementation. Extensive IT changes or a replacement IT system will be needed to meet the new Medicaid and exchange requirements under the ACA.

c. For what kinds of activities are States likely to seek funding using the Exchange establishment and planning grants?

Kentucky will use some of the planning grant funds: to conduct background research on the Commonwealth's insurance market; including the uninsured population; to conduct an assessment of the current Medicaid eligibility system and determine system needs to implement an exchange; to hold stakeholder meetings throughout the state; and to hire additional staff.

5. What kinds of questions are States likely to receive during the initial planning and start-up phase of establishing Exchanges? How can HHS provide technical assistance, and in what forms, in helping States to answer these questions?

In preparing for an exchange IT system, guidance is needed on how income and household composition will be defined for Medicaid eligibility, exchange eligibility, and premium subsidies. Detail is needed about the interfaces with the exchange and federal agencies such as Homeland Security, Internal Revenue Service, Social Security, etc. The extent to which HHS will require states to utilize old Medicaid rules versus new Medicaid rules for eligibility determinations in order to claim the appropriate FMAP rate.

It would be helpful if HHS would provide timely answers to questions submitted by various states and other stakeholders in writing after consultation with stakeholders. The process used during the HIPAA implementation (FAQs posted online and updated frequently) was helpful in the past. States would benefit from early HHS decisions regarding benefit plan designs to be offered in the Exchange and the definition of modified adjusted gross income (MAGI).

B. Implementation Timeframes and Considerations

Section 1321(b) requires each State that elects to establish an Exchange meeting the Secretary's requirements to have an Exchange operational by January 1, 2014. Section 1321(c) directs the Secretary to establish and operate an Exchange within each State that: (1) Does not elect to establish an Exchange; or (2) the Secretary determines will not have an Exchange operational by January 1, 2014, or has not taken the actions the Secretary determines necessary to implement the requirements in Section 1321(a) or the other insurance market reform requirements in Subtitles A and C of Title I of the Act.

Additionally, the Affordable Care Act includes several statutory deadlines for the Secretary related to establishment of Exchanges, including:

Issuing regulations and/or guidance relating to requirements for Exchanges, requirements for QHPs, and risk adjustment as soon as practicable;

Awarding State planning grants no later than one year after enactment (March 23, 2011); Determining the dates of the initial open enrollment period by July 1, 2012; No later than January 1, 2013, determining States' readiness to have Exchanges operational and implement required insurance market reforms by January 1, 2014; No later than July 1, 2013, issuing regulations for health choice compacts and the CO-OP program, and awarding CO-OP program grants; and

Having in place additional insurance market reforms and providing cost-sharing reductions beginning on January 1, 2014.

In order to carry out the Federal implementation activities to ensure Exchanges are fully operational on January 1, 2014, the Department is seeking comments from stakeholders relating to implementation timeframes.

1. What are the key implementation tasks that need to be accomplished to meet Exchange formation deadlines and what is the timing for such tasks? What kinds of business functions will need to be operational before January 1, 2014, and how soon will they need to be operational?

Key implementation tasks include: Enabling Legislation; Determine Source of Funding for Exchanges; development of an IT system; development of organizational structure and hiring of staff and procurement of necessary vendors.

Additionally, HHS Guidance is needed regarding relevant topics such as: Essential Health Benefits, certification standards for QHPs (ability to offer buy-up options with the levels of coverage) risk adjustment options, reporting requirements, and the final design of uniform coverage documents; subsidiary products within the exchange; and the establishment of Basic Health Program.

2. What kinds of guidance or information would be helpful to States, plans, employers, consumers, and other groups or sectors as they begin the planning process?

If specific guidance cannot be provided, a timeline stating when this guidance will be available. Guidance on the essential health benefits is crucial to the development of the exchange. Guidance regarding the participation of agents. Guidance regarding the navigator program.

3. What potential criteria could be considered in determining whether an electing State is making sufficient progress in establishing an Exchange and implementing the insurance market reforms in Subtitles A and C of Title I of the Affordable Care Act? What are important milestones for States to show they are making steady and sufficient progress to implement reforms by the statutory deadlines? Important milestones would include:

Enabling statutes/regulations, stakeholder meetings, procurement or development of IT system changes, and a viable business plan.

4. What other terms or provisions require additional clarification to facilitate implementation and compliance? What specific clarifications would be helpful?

States need guidance on how Co-Ops can be formed and operate within a state and how to ensure that Co-Ops are regulated by the state. States also need the definition of "unreasonable" rate increases, and "essential health benefits." Clarification of what mandated benefits would trigger the requirement that

the state assume cost of benefits in section 1311(d) is needed. Clarification of federal requirements for determining Medicaid under the old categories versus the new income based eligibility categories. It would be advantageous for states and consumers to utilize the simplest method for assessing and determining Medicaid eligibility.

C. State Exchange Operations

Section 1311(b) requires an Exchange to be established in each State not later than January 1, 2014 that: Facilitates the purchase of QHPs; provides for the establishment of a SHOP Exchange that assists small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State; and meets additional requirements for Exchanges outlined in Section 1311(d). The Act requires the Secretary to publish regulations relating to the requirements for operating State Exchanges as soon as practicable, and provides various types of flexibility for States.

A number of additional programs established by the Act are closely related to the establishment of health insurance Exchanges, such as the Navigator program in Section 1311(i) and other consumer assistance programs. In addition, the insurance reforms, consumer protection provisions, and premium rating requirements will apply to plans both inside and outside the Exchanges.

1. What are some of the major considerations for States in planning for and establishing Exchanges?

See above.

2. For which aspects of Exchange operations or Exchange standards would uniformity be preferable? For which aspects of Exchange operations or Exchange standards is State flexibility likely to be particularly important?

Flexibility: ability to accommodate local regional carriers and Employer Organized Associations in the exchange, Navigator and Consumer Assistance Program standards to meet state specific demographics. Above the Federal Standards, flexibility to design products for the exchange.

Uniformity: System for Enrollment, uniform application. Uniform minimum standards for insurer/QHP certification for exchange participation. Uniform data reporting to the Secretary. Standards for provider participation. Uniform eligibility determinations between Medicaid and the exchange. Uniform/streamlines verification methods with federal agencies to determine eligibility for Medicaid and eligibility for tax credits and premium subsidies assistance.

3. What kinds of systems are States likely to need to enable important Exchange operational functions (e.g., eligibility determination, plan qualification, data reporting, payment flows, etc.), to ensure adequate accounting and tracking of spending, provide transparency to Exchange functions, and facilitate financial audits? What are the relative costs and considerations associated with building Exchange operational, financial, and/or IT systems off of existing systems, versus building new stand-alone Exchange IT systems?

The Commonwealth is soliciting comments from insurers regarding the system requirements needed to allow the exchange to receive and transmit information to carriers' systems. Sophisticated system upgrades will be required for eligibility, premium accounting, etc. A best practice may be to develop a stand-alone IT system.

One of the considerations when deciding to build off existing systems or to build new stand alone IT systems is the age and functionality of existing systems. Many existing systems in the Commonwealth such as our Medicaid/CHIP eligibility system are legacy systems which will not easily adapt to the web-based requirements set forth for the Exchange.

4. What are the tradeoffs for States to utilize a Federal IT solution for operating their Exchanges, as compared to building their own unique systems to conform to the current State environment? For what kinds of functions would it make more sense for States to build their own systems, or modify existing systems?

For those functions which will be uniform across all states, it would be beneficial for this functionality to exist at the federal level. The federal agencies responsible for verification related to eligibility for enrollment through an exchange should build standard secure interfaces that the states can use. It would be helpful to employ the use of "web services" for this verification that the states can access from their IT systems.

5. What are the considerations for States as they develop web portals for the Exchanges?

States will need to develop the most simple and easy to use consumer facing page in order to facilitate consumer understanding and communication. Additional guidance is needed regarding uniform summary of benefits. Consumers will need live assistance available as well as an option to inquire online regarding their benefits. Federal agencies should build templates to be customized by the states on all communication material including easy to understand brochures, FAQs, tip Sheets etc.

States need to understand which functionality will be provided by the federal systems and which functionality they will be responsible for providing. Complex IT systems can take years to build. States must get started now in order to meet the 2014 deadline.

6. What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs? How will States leverage/coordinate the work funded by the rate review grants to inform the decisions about which plans will be certified by QHPs?

Whether or not the applicable state has approved the premium increase, actuarially justified, insurer financial solvency. The Commonwealth plans to increase the detail of rate review already performed by the Department of Insurance and would consider implementing a procedure to make information available to the exchange regarding insurer certification based upon past premiums.

7. To what extent are Territories likely to elect to establish their own Exchanges? What specific issues apply to establishing Exchanges in the Territories?

N/A

8. What specific planning steps should the Exchanges undertake to ensure that they are accessible and available to individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

Our background research will capture information about demographics of all consumers in the Commonwealth (including if English is the primary language and average reading level). The Commonwealth hopes to hire staff members who speak other languages for the consumer outreach positions. In lieu of that, the Commonwealth will use a translating phone service.

An outreach effort for hard to reach populations that are specific to cultural groups will be needed. Access mechanisms for individuals that are deaf, hard of hearing, and blind will be developed. Live assistance from the exchange, Medicaid agency, and community partners will also be essential.

9. What factors should the Secretary consider in determining what constitutes wasteful spending (as outlined in Section 1311 (d)(5)(B))?

The Secretary should consider if the funds expended are meant to assist in the efficient and effective administration of an exchange. The exchange should be required to maintain internal standards and states should have flexibility in the types of expenditures that are necessary. The Commonwealth believes that the use of and payment of agents by the exchange should not be considered "wasteful spending". Agents are a vital component in the success or failure of an exchange.

D. Qualified Health Plans (QHPs)

Section 1311(d)(2)(A) requires Exchanges to make QHPs available to qualified individuals and employers, and Section 1311(d)(4)(A) requires Exchanges to implement procedures for the certification, recertification, and decertification of health plans as QHPs, consistent with criteria developed by the Secretary under section 1311(c). This certification criteria include, at a minimum: Meeting marketing requirements; ensuring a sufficient choice of providers and providing information on the availability of providers; including essential community providers within health insurance plan networks; receiving appropriate accreditation; implementing a quality improvement strategy; utilizing a uniform enrollment form and a standard format to present health benefit plan options; and providing quality information to enrollees and prospective enrollees.

1. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP State Exchanges, subsidiary Exchanges, regional or interstate Exchanges, or an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange?

States must consider ways to encourage participation in the exchange by insurers. For states that have limited carrier options, certifications standards would need to be minimal. For states with more carrier choices, the state could set more stringent certification standards and still have adequate participation. Therefore, any federal certification standards should be drafted to allow state flexibility in order to accommodate the varying markets (such as the need for regional carriers with smaller concentrated networks, etc).

2. What factors should be considered in developing the Section 1311(c) certification criteria? To what extent do States currently have similar requirements or standards for plans in the individual and group markets?

Insurers should be licensed and in good standing (including financial solvency) with the state offering the exchange. The majority of these criteria appear in NAIC model laws or existing state statutes. Federal criteria should take into account these model laws or other national accreditation standards (such as NCQA) rather than recreate additional standards that overlap current standards.

Any certification requirement related to cost must give consideration and account for differences based on benefit design, claims experience, negotiated reimbursement, provider networks, and other items to ensure that benefit are reasonable in relation to premium amounts.

a. What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of providers?

The Commonwealth already has in place network adequacy standards and some guarantees for provider choice. There are many regional carriers that utilize small networks that add value to state markets. These limited networks should be evaluated distinct from state-wide or national networks.

b. What issues need to be considered in establishing appropriate minimum standards for marketing of QHPs and enforcement of those standards? What are appropriate Federal and State roles in marketing oversight?

The Commonwealth has in place statutes governing advertising. Advertising should be reviewed to ensure that statements are not misleading or inaccurate.

3. What factors are needed to facilitate participation of a sufficient mix of QHPs in the Exchanges to meet the needs of consumers?

QHP certification procedures should be minimal and state specific. Insurers should be given flexibility in benefit design in each level of coverage option, including buy-up options.

a. What timeframes and key milestones will be most important in assessing plans' participation in Exchanges?

All processes depend on HHS guidance on essential benefits and certification requirements of QHPs.

Stakeholder meetings during the planning period (2010-2011) with assist the Commonwealth to determine the insurer's interest in participation and concerns with plan design.

b. What kinds of factors are likely to encourage or discourage competition among plans in the Exchanges based on price, quality, value, and other factors?

Over-regulation or onerous certification requirements on QHPS will discourage competition. Flexibility to negotiate provider rates will be the only competitive option for QHPS. The same rules and regulatory environment must apply to provide a level playing field inside and outside the exchange.

4. What health plan standards and bidding processes would help to facilitate getting the best value for consumers and taxpayers?

Unknown at this time.

5. What factors are important in establishing minimum requirements for the actuarial value/level of coverage?

Benefit design, scope of coverage, cost-sharing, existence of state added benefits requirements.

6. What factors, bidding requirements, and review/selection practices are likely to facilitate the participation of multiple plans in Exchanges? To what extent should the Exchanges accept all plans that meet minimum standards or select and negotiate with plans?

In states with multiple issuers wishing to participate in the exchange, more stringent requirements might be acceptable. In states with few issuers wishing to participate, the exchange may need to accept all plans in order to facilitate competition. However, there are adverse selection issues if the exchange accepts all plans.

7. What are some important considerations related to establishing the program to offer loans or grants to foster the promotion of qualified nonprofit health plans under CO-OP plans? How prevalent are these organizations today? What is the likely demand for these loans and grants? What kinds of guidance are they likely to need from HHS and what legislative or regulatory changes are they likely to need from States?

Unknown at this time.

8. Are there any special factors that are important for consideration in establishing standards for the participation of multi-State plans in Exchanges?

Unknown at this time. These plans should comply with consumer protections and should not cause disruption to the Kentucky insurance market and the exchange.

9. To what extent are States considering setting up State Basic Health Plans under Section 1331 of the Act?

Unknown at this time.

E. Quality

The Affordable Care Act requires the Secretary to develop a health plan rating system on the basis of quality and prices that would be used by the Exchanges and to establish quality improvement criteria that health plans must meet in order to be qualified plans for Exchanges.

1. What factors are most important for consideration in establishing standards for a plan rating system?

Health outcomes, complaint ratio, consumer satisfaction, plans' promotion of wellness and prevention program.

a. How best can Exchanges help consumers understand the quality and cost implications of their plan choices?

Simple and easily-understood language provided on a comparative basis for the plan choices. Materials available on-line and in hard-copy formats to educate consumers regarding plan choices.

b. Are the measures and standards that are being used to establish ratings for health plans in the Medicare Advantage program appropriate for rating QHPs in the Exchanges? Are there other State Medicaid or commercial models that could be considered?

Unknown at this time.

c. How much flexibility is desirable with respect to establishing State-specific thresholds or quality requirements above the minimum Federal thresholds or quality requirements?

Too many additional requirements in excess of the federal thresholds might discourage participation. Uniformity in this area is desirable.

2. What are some minimum standards or other factors that could be considered with respect to establishing quality measurement and improvement thresholds or quality requirements that should be met by QHPs? What other strategies, including payment structures, could be used by plans to improve the practices of plan providers?

Utilization of existing national accreditation standards such as NCQA. Additional standards or factors are unknown at this time.

F. An Exchange for Non-Electing States

Section 1321(c) requires that in the case of States that do not elect to establish Exchanges, or that the Secretary determines will not have Exchanges operational by January 1, 2014 or have not taken the necessary actions to implement the requirements in Section 1321(a) or other insurance market reforms specified in Subtitles A and C of Title I of the Act, the Secretary shall establish (directly or through agreement with a not-for-profit entity) and operate an Exchange within the State.

1. How can the Federal government best work to implement an Exchange in States that do not elect to establish or are unable to establish their own Exchanges?

The Federal government should openly communicate with the state and insurance regulators to prevent disruption and unintended consequences in the state insurance market.

2. Are there considerations for an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange that would be different from the State-run Exchanges?

The ability to handle internal and external appeals. Which state laws and federal laws will apply to a federal-run exchange?

G. Enrollment and Eligibility

Section 1411 of the Affordable Care Act requires the Secretary to establish a program for determining whether an individual meets certain eligibility requirements for Exchange participation, premium tax credits and cost-sharing reductions, and individual responsibility exemptions. Additionally, Sections 1412, 1413 and 2201 contain additional requirements to assist Exchanges by making advance determinations regarding income eligibility and cost-sharing reductions; providing for residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in applicable State health subsidy programs; and simplifying and coordinating enrollment in the Exchanges, Medicaid and the Children's Health Insurance Program (CHIP).

1. What are the advantages and issues associated with various options for setting the duration of the open enrollment period for Exchanges for the first year and subsequent years? What factors are important for developing criteria for special enrollment periods?

It would be disadvantageous for the exchange to have an open enrollment period. In the individual market, the exchange should have continuous open enrollment. In the group market, special enrollment periods inside the exchange should match the current special enrollment periods required in the insurance market outside of the exchange.

2. What are some of the key considerations associated with conducting online enrollment?

A simple user friendly application and process. Availability of interactive or live assistance for questions. Making access points for individuals who do not have computers available at home. Mechanism for contact with applicants for follow up questions or to confirm information. Degree to which exchange and Medicaid eligibility system are fully integrated.

States need a system which is flexible enough to determine plans for which the individual may be eligible. The system should have wizards which guide the user through the enrollment process based on the answers to the previous questions. The system design should be such that the user only has to answer questions which pertain to their situation and does not overwhelm the user.

3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

a. States eligibility systems need to be web based to be adaptable for use in the Exchange. Uniform income verification across all programs would ease administrative burden. Existing Medicaid/CHIP eligibility systems contain complicated eligibility requirements. For these systems to be used to determine eligibility for all three programs, policy and

legislative changes would be required to standardize eligibility requirements. Also, benefit plan design needs to be standardized as much as possible across all the programs, so that if a user does change the eligibility across programs the consumer does not have to worry about the schedule of benefits or the provider network.

b. A significant concern is the possibility of the burdensome task of completing Medicaid and exchange eligibility determinations utilizing two different methodologies. The exchange will consider Modified Adjusted Gross Income (MAGI) and household size based on previous year's tax returns. This is not consistent with the current Medicaid eligibility rules. The most effective coordination between Medicaid, CHIP and the Exchange would be to utilize the same standards across the board. Differences between the Exchange eligibility methods and Medicaid/CHIP eligibility methods will create complications and result in administrative burdens in determining eligibility. Additionally, it will increase the burden for individuals who wish to enroll and may even deter their enrollment.

The differences between the Exchange and existing Medicaid rules include the following:
The current rules for covering non-disabled adults (the old AFDC rules from 1996) include the consideration of resources, deprivation factors, and the need for the parents to cooperate with Medical Support Enforcement activities in order to be included in the benefit group. This information will not be readily available for online verification.

Income rules:

1) The exchange will be using tax return income but Medicaid is required to determine eligibility "as of the point in time an application is processed." The previous year's tax returns are not always reflective of current household income. States would benefit from the establishment of a universal "Work Number" that allows rapid access to current income or a data match that is more current that the State's wage data file, which only reflects the prior quarter's income rather than current income.

2) The exchange will consider income of all individuals included on a tax return. Medicaid rules only count the income of individuals legally responsible for care and maintenance of another person. For example, a step parent is not responsible for a child until such time as he adopts that child; a minor or emancipated sibling is not responsible for the other sibling. Currently when parents share equal custody, Medicaid counts both parents income as available to the child. ACA appears to be changing this rule based on the language regarding household income, clarification of this is needed.

Household composition:

- Under current Medicaid eligibility rules for the composition of a non-disabled adult household, the relationship among the household

members plays a significant role when determining the individuals that can be included in the eligibility group.

In order to have consistency and between exchange eligibility and Medicaid eligibility and simplify the eligibility determination process, the following changes are recommended:

- Eliminate the caretaker relative rules as these adults no longer need a child to qualify for eligibility.
- Clarify and simplify guidance relating to household composition and income consideration.
- Establish a data match method to obtain and verify current income.
- Include in the exchange uniform application, a question concerning the relationship between household members.

c. The enhanced FMAP rate for "new eligible's" will be problematic in determining the Medicaid eligibility for non-disabled adults. Historically, Federal Medicaid rules have been amended to encourage states to simplify and streamline the eligibility determination process for many existing groups, including child only cases for both Medicaid and CHIP. However, mandatory eligibility groups that follow the AFDC rules from 1996 continue to have intrusive questions relating to deprivation and work history as well as the consideration of resources. Requiring states to apply the AFDC rules to the "new eligible's" is burdensome and onerous and will complicate the eligibility determination process. It was recommended that states be allowed to not utilize the AFDC rule for "new eligible's", and that a statistical alternative method be developed and applied to the "new eligible's" to determine the number of individuals who would have been eligible under the AFDC rule.

4. What kinds of data linkages do State Medicaid and CHIP agencies currently have with other Federal and State agencies and data sources? How can the implementation of Exchanges help to streamline these processes for States, and how can these linkages be leveraged to support Exchange operations?

The Commonwealth's eligibility system currently has batch interfaces with the IRS and the state's Unemployment Insurance agency. A real-time interface with the Social Security Administration to verify SSNs occurs for new individuals seeking eligibility. The eligibility system also has numerous interfaces with state agencies for information such as death files, birth registration system, child support income, etc. The Commonwealth uses the MMIS (Medicaid Management Information System) for both Medicaid and CHIP populations. Kentucky MMIS exchanges various files with CMS including the EDB (Enrollment Data Base) and MSIS (Medicaid Statistical Information System).

5. How do States or other stakeholders envision facilitating the requirements of Section 1411 related to verification with Federal agencies of eligibility for enrollment through an Exchange?

Kentucky recommends that the federal agencies maintain a single database for state verification of enrollment for exchange and Medicaid eligibility.

The federal agencies responsible for verification related to eligibility for enrollment through an exchange should build standard secure interfaces that the states can use. It would be helpful to employ the use of "web services" for this verification that the states can access from their IT systems.

6. What are the verification and data sharing functions that States are capable of performing to facilitate the determination of Exchange eligibility and enrollment?

The Commonwealth has many existing interfaces with state agencies. Some of these interfaces could be used in facilitating the determination of eligibility and enrollment in the Exchange. The Commonwealth does batch and real time verification functions in our systems, but would prefer real time interfaces in the Exchange as they have less of an administrative operational burden, though they are more sophisticated to implement.

7. What considerations should be taken into account in establishing procedures for payment of the cost-sharing reductions to health plans?

This issue is complex and the procedures will likely be detailed. However, to the insured individuals, this will need to be communicated very simply. The process will need to be as administratively simple as possible in order to curb the added administrative burden and expense for the exchange and for insurers.

H. Outreach

Section 1311(i) provides that Exchanges shall establish grant programs for Navigators, to conduct public education activities, distribute enrollment information, facilitate enrollment, and provide referrals for grievances, complaints, or questions.

1. What kinds of consumer enrollment, outreach, and educational activities are States and other entities likely to conduct relating to Exchanges, insurance market reforms, premium tax credits and cost-sharing reductions, available plan choices, etc., and what Federal resources or technical assistance are likely to be beneficial?

The Commonwealth will use printed materials, web based materials, town forums, media, etc. to communicate information to the public about the exchange and assistance available to consumers from the Cabinet for Health and Family Services and the Department of Insurance. It would be beneficial for the federal government to sponsor a national ad campaign to educate the public about health insurance market reforms, exchanges, premium subsidies, and tax credits.

Interested health, education, human services and community agencies will be educated about available health coverage and will provide educational materials and discuss health coverage as part of their routine contacts with clients.

The Department of Insurance will make available a consumer ombudsman, funded by federal grant dollars, to assist consumers with enrollment, eligibility and access issues.

2. What resources are needed for Navigator programs? To what extent do States currently have programs in place that can be adapted to serve as patient Navigators?

Kentucky has a wide variety of community based organizations that would be successful Navigators. Examples include: local health departments, family resource and youth services centers, community action agencies, churches, libraries, etc.

The biggest concern for the Commonwealth is that there is no federal funding available for the Navigator Program. Given the current budget situation, it will be extremely difficult for Kentucky to provide grants for the Navigator Program.

Guidance will be necessary regarding the level of certification required for a Navigator including required training or education. We recommend that Navigator certification requirements not prevent community based organizations from participating in this function. Information regarding the interaction between licensed agents and navigators would be helpful.

3. What kinds of outreach strategies are likely to be most successful in enrolling individuals who are eligible for tax credits and cost-sharing reductions to purchase coverage through an Exchange, and retaining these individuals? How can these outreach efforts be coordinated with efforts for other public programs?

Education of the public that subsidies/credits are available only through the exchange will attract and retain individuals. Education will be through the outlets listed in question H.1.

I. Rating Areas

Section 2701(a)(2) of the Public Health Service Act, as added by Section 1201 of the Affordable Care Act requires each State to establish one or more rating areas within the State for purposes of applying the requirements of Title I of the Affordable Care Act (including the Exchange provisions), subject to review by the Secretary.

1. To what extent do States currently utilize established premium rating areas? What are the typical geographical boundaries of these premium rating areas (e.g., Statewide, regional, county, etc.)? What are the pros and cons associated with interstate, statewide, and sub-State premium rating areas? What insurance markets are typically required to utilize these premium rating areas?

The Commonwealth currently utilizes a regional approach based upon eight regions within the state. Using a regional approach allows for varying cost and utilization of medical care for specific geographic areas (varying provider reimbursements, network deficiencies, municipal premium taxes, etc) and prohibits subsidization between regions. Using a statewide approach would lead to cross-subsidization between areas. All insurance markets in Kentucky rate by region.

2. To the extent that States utilize premium rating areas, how are they established? What kinds of criteria do States and other entities typically consider when determining the adequacy of premium rating areas? What other criteria could be considered?

Kentucky's rating regions are based upon groupings of counties to ensure equal representation for medically underserved areas. The current system has been in place for many years and works well for our market. The current boundaries have not been controversial.

J. Consumer Experience

1. What kinds of design features can help consumers obtain coverage through the Exchange? What information are consumers likely to find useful from Exchanges in making plan selections? Which kinds of enrollment venues are likely to be most helpful in facilitating individual enrollment in Exchanges and QHPs?

Consumers will need easy to read plan summaries with a useful comparison tool in order to determine differences in benefits between qualified health plans. Consumers will want to understand clearly what each plan will cost, and what out of pocket/coinsurance they will be responsible for. Consumers will need to understand what conditions are excluded. Examples for how common types of claims will be paid under each plan would also be helpful.

Agents and consumers find the Medicare Supplement comparison tools on Medicare.gov helpful. Exchange pages should learn from this type of comparison tool.

There should be a variety of enrollment venues available. Most consumers will not be willing to go to a Welfare Office due to a perceived stigma. The best option for consumers will be to enroll online. Options for those that cannot access the internet will be explored during the grant planning process.

2. What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select (within or outside of an Exchange)? What are some best practices in conveying information to consumers relating to health insurance, plan comparisons, and eligibility for premium tax credits, or eligibility for other public health insurance programs (e.g., Medicaid)? What types of efforts could be taken to reach individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

See Q.1.

3. What are best practices in implementing consumer protection standards?

It is crucial that information regarding compliance with new consumer protections (e.g. safe harbors, best practices) be clearly communicated in writing in advance of the implementation deadline. Insurers need adequate time to implement changes and makes required revisions to policy documents. Additional time is needed to allow for state review and approval of forms and rates.

Federal guidance, such as FAQs and Bulletins, are extremely useful to regulators and insurers in the implementation process.

4. Given that consumer complaints can be an important source of information in identifying compliance issues, what are the pros and cons of various options for collecting and reporting Exchange-related complaints (e.g., collecting complaints at the Federal level, versus at the State or Exchange level)?

The Commonwealth is in favor of state collection of complaints. State regulators can respond quicker to local complaints and take necessary action. If the consumer isn't satisfied with the state resolution of their complaint they could be given the option to contact federal agencies for further review.

Complaints could be reported to the Federal level from the State on a periodic basis as a repository and determine areas in need of improvement.

K. Employer Participation

Section 1311(b)(1)(B) provides for the establishment of Small Business Health Options Programs, referred to as SHOP Exchanges, which are designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State. Section 1304(b) provides that for plan years beginning before January 1, 2016, States have the option to define ``small employers'' as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Section 1312(f)(2)(B) specifies that beginning in 2017, States may elect to include issuers of health insurance coverage in the large group market to offer QHPs through the Exchange, and for large employers to purchase coverage through the Exchange.

In addition, employers that do not offer affordable coverage to their employees will also interact with the Exchanges including where their employees purchase coverage through the Exchange.

1. What Exchange design features are likely to be most important for employer participation, including the participation of large employers in the future? What are some relevant best practices?

In meeting with employer stakeholders, the Commonwealth has found that employers are concerned about ease of use and affordability. Most small employers do not have a large HR department and therefore they need a simple solution for eligibility determination, enrollment, and premium payment. Additionally, most employers, small and large, rely upon their agent for insurance advice and direction. The exchange should be designed to allow employees to easily access coverage, allow agents to assist employers and employees with enrollment functions, and instruct employees how to make premium payment to carriers.

Some employers will be deterred from accessing the exchange if they will be required to make multiple premium payments to multiple insurers every month for their employees as well as track the premium subsidies for their qualified employees. This could be burdensome. Therefore, this process must be simple.

2. What factors are important for consideration in determining the employer size limit (e.g., 50 versus 100) for participation in a given State's Exchange?

Currently the Commonwealth defines a small employer as 2-50 employees. At this time, the Commonwealth is concerned changing this definition could cause market instability. Our recommendation is to retain any applicable state definition until such time as the exchanges have been established and are fully operational.

3. What considerations are important in facilitating coordination between employers and Exchanges? What key issues will require collaboration?

The exchange will need to establish standards for accepting information from employers regarding plan elections (such as bronze, silver, gold, and platinum) and employer contribution level. The exchange will also need to establish standards for transmitting information to employers (such as subsidy determinations, premium cost). Reporting will need to have consistent timeframes and be concise. Employers will need clear instruction, including simple online access to the exchange.

Some employers do not have electronic capability; therefore the exchange may need to accept and engage in paper reporting.

4. What other issues are there of interest to employers with respect to their participation in Exchanges?

The relative cost of coverage within the exchange, outside the exchange, and self-insurance options are vital to employers in trying to determine how they will provide coverage to their employees. Employers will be interested in whether their employees qualify for subsidies in determining whether it is in their best interest to participate in the exchange.

Employers will be concerned about whether other employers in their industry will be participating in the exchange, dropping coverage all together, or continuing to other coverage outside the exchange.

L. Risk Adjustment, Reinsurance, and Risk Corridors

Sections 1341, 1342, and 1343 of the Act provide for the establishment of transitional reinsurance programs, risk corridors, and risk adjustment systems for the individual and small group markets within States.

1. To what extent do States and other entities currently risk-adjust payments for health insurance coverage in order to counter adverse selection? In what markets (e.g., Medicaid, CHIP, government employee plans, etc.) are these risk adjustment activities currently performed? To the extent that risk adjustment is or has been used, what methods have been utilized, and what are the pros and cons of such methods?

The Commonwealth has a high risk pool, Kentucky Access, and therefore there is no need to provide a risk adjustment method to private insurers.

2. To what extent do States currently collect demographic and other information, such as health status, claims history, or medical conditions under treatment on enrollees in the individual and small group markets that could be used for risk adjustment? What kinds of resources and authorities would States need in order to collect information for risk adjustment of plans offered inside and outside of the Exchanges?

The Commonwealth receives high level enrollment and claims information broken down by market segment and product type. The current data collected is not sufficient to do risk adjustment activities. More detailed demographic data would be needed. The Department of Insurance currently has sufficient authority to collect additional data. More research will be needed regarding risk adjustment prior to determining when and if additional data will be collected. The Commonwealth will be examining this issue during the exchange planning process.

3. What issues are States likely to consider in carrying out risk adjustment for health plans inside and outside of the Exchanges? What kinds of technical assistance might be useful to States and QHPs?

Experience should be pooled for plans offered inside and outside of the exchange. Dividing the pool would lead to adverse experience and selection.

Structures to be considered include: same pricing for plans offered inside and outside the exchange; in the individual market, requiring any plan offered outside the exchange to be offered inside the exchange.

The Commonwealth will determine the risk adjustment structure that is appropriate for our market. Therefore, sufficient flexibility to states must be preserved.

4. What are some of the major administrative options for carrying out risk adjustment? What kinds of entities could potentially conduct risk adjustment or collect and distribute funds for risk adjustment? What are some of the options relating to the timing of payments, and what are the pros and cons of these options?

It is premature at this time for the Commonwealth to make a recommendation on this issue.

5. To what extent do States currently offer reinsurance in the health insurance arena (e.g., Medicaid, State employee plans, etc.) or in other arenas? How is that reinsurance typically structured in terms of contributions, coverage levels, and eligibility? How much is typically taken in and paid out? Is the reinsurance fund capped in any way?

The Commonwealth does not currently offer reinsurance in the insurance market. Medicaid, Kentucky Access and the state employee health plan are not reinsured.

6. What kinds of non-profit entities currently exist in the marketplace that could potentially fulfill the role of an ``applicable reinsurance entity'' as defined in the Act?

Unknown at this time.

7. What methods are typically used to determine which individuals are deemed high-risk or high cost for the purposes of reinsurance?

In the private market, a person is determined high cost by the aggregate claim dollars spent during a specific time period. For purposes of the Kentucky high risk pool, this is a list of high cost conditions set forth in statute.

8. What challenges are States likely to face in implementing the temporary reinsurance program?

This will be an entirely new process for the market. The Commonwealth is concerned that there is not an available entity to function as an "applicable reinsurance entity", therefore there will be challenges in identifying and selecting this entity.

9. How do other programs (e.g., Medicaid) use risk corridors to share profits and losses with health plans or other entities? How are the corridors defined and monitored under these programs? What mechanisms are used to collect and disburse payments?

This is not a mechanism currently used in the Commonwealth.

10. Are there non-Federal instances in which reinsurance and/or risk corridors and/or risk adjustment were used together? What kinds of special considerations are important when implementing multiple risk selection mitigation strategies at once?

Unknown at this time.

M. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

Executive Order 12866 requires an assessment of the anticipated costs and benefits of a significant rulemaking action and the alternatives considered, using the guidance provided by the Office of Management and Budget. These costs and benefits are not limited to the Federal government, but pertain to the affected public as a whole. Under Executive Order 12866, a determination must be made whether implementation of the Exchange-related provisions in Title I of the Affordable Care Act will be economically significant. A rule that has an annual effect on the economy of $100 million or more is considered economically significant.

In addition, the Regulatory Flexibility Act may require the preparation of an analysis of the economic impact on small entities of proposed rules and regulatory alternatives. An analysis under the Regulatory Flexibility Act must generally include, among other things, an estimate of the number of small entities subject to the regulations (for this purpose, plans, employers, and in some contexts small governmental entities), the expense of the reporting, recordkeeping, and other compliance requirements (including the expense of using professional expertise), and a description of any significant

regulatory alternatives considered that would accomplish the stated objectives of the statute and minimize the impact on small entities.

The Paperwork Reduction Act requires an estimate of how many ``respondents'' will be required to comply with any ``collection of information'' requirements contained in regulations and how much time and cost will be incurred as a result. A collection of information includes recordkeeping, reporting to governmental agencies, and third-party disclosures.

Furthermore, Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $135 million.

The Department is requesting comments that may contribute to the analyses that will be performed under these requirements, both generally and with respect to the following specific areas:

1. What policies, procedures, or practices of plans, employers and States may be impacted by the Exchange-related provisions in Title I of the Affordable Care Act?

The Affordable Care Act presents sweeping changes to the market, to plans, to employers, and to state regulatory practice. It will have a significant impact.

a. What direct or indirect costs and benefits would result?

There will be significant expense in developing new IT systems, hiring and training of staff, communication and outreach efforts.

b. Which stakeholders will be affected by such benefits and costs?

Employers, Providers, Insurers, Agents, State agencies (including Medicaid), Consumers.

c. Are these impacts likely to vary by insurance market, plan type, or geographic area?

There may be some slight variation, but all will be significantly impacted.

2. Are there unique effects for small entities subject to the Exchange-related provisions in Title I of the Affordable Care Act?

Small insurers may be negatively impacted. Small Employers may elect to discontinue employer-based coverage. Health insurance agents may face a decline in their business.

3. Are there unique benefits and costs affecting consumers? How will these consumer benefits be affected by States' Exchange design and flexibilities and the magnitude and substance of provisions mandated by the Act? Please discuss tangible and intangible benefits.

Unknown at this time.

4. Are there paperwork burdens related to the Exchange-related provisions in Title I of the Affordable Care Act, and, if so, what

estimated hours and costs are associated with those additional burdens?

Unknown at this time.

N. Comments Regarding Exchange Operations

The Exchange-related provisions in Title I of the Affordable Care Act may affect/will involve various stakeholders. HHS wants to ensure receipt of all comments pertaining to the operations of the Exchanges.

1. What other considerations related to the operations of Exchanges should be addressed? If your questions related to the operations of Exchanges have not been asked, or you would like to add additional comments, you may do so here.